DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

16. Inpatient Psychiatric Services:

Inpatient psychiatric services for individuals under age 21 provided under the direction of a physician who is at least board eligible in psychiatry and has experience in child/adolescent psychiatry provided in either a licensed psychiatric hospital that meets the requirements of 42 CFR 482.60 and 1861(f) of the Social Security Act or a psychiatric unit of a general hospital that meets the requirements of subparts B and C of 42 CFR 482 and Subpart D of 42 CFR 441 or a licensed psychiatric residential treatment facility (PRTF) that meets the requirements Section 1905(h) of the Act. All of the above named facilities must have Joint Commission on Accreditation of Health Care Organization (JCAHO) accreditation. The psychiatric service must be provided in accordance with an individual comprehensive services plan as required by 42 CFR 441.155(b) before the individual reaches age 21 or, if the individual was receiving the services immediately before obtaining age 21, before the earlier of the date the individual no longer requires the services or the date the individual reaches age 22. The setting in which the psychiatric services are provided shall be certified in writing to be necessary as required by 42 CFR 441.152. Recipients shall be allowed forty-five days, or longer if prior approved as medically necessary, in psychiatric hospitals or in a psychiatric unit of a general hospital and shall be allowed unlimited days of service if medically necessary in a PRTF.

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

17. Midwifery Services — Limited to the following procedures:

| | |
|---|---|
| 59410 | Vaginal delivery only (with or without forceps and/or episiotomy) postpartum |
| 59420 | Antepartum care only (independent procedure) - per visit |
| 59430 | Postpartum checkup (independent procedure) - per visit |

All claim forms must be signed by the duly licensed physician under whom any of the above services were rendered.

Participation limited to certified nurse midwives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

18. Hospice Care - Hospice benefits include the same services and limitations thereon as available under the Medicare program. Election of the hospice option causes the recipient to forfeit all other Medicaid program benefits that are related to the treatment of the individual's terminal illness or are duplicative of hospice care, but only if those services are also provided by Medicare. The exceptions to this are the services of a physician that is not employed by the hospice and is primarily responsible for the care of the recipient. Four (4) benefit periods; 90, 90, 30 and unlimited days are available provided a physician certifies that the recipient is terminally ill or that the condition of the recipient has not changed since the previous certification of terminal illness.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19a Targeted case management services to chronically mentally ill community based recipients.

All Medicaid services are provided to the chronically mentally ill within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Case management services may be provided as a component part of the service by any qualified Medicaid provider.

see letter

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

19a Targeted case management services to developmentally disabled community based recipients.

All Medicaid services are provided to the developmentally disabled within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Case management services may be provided as a component part of the service by any qualified Medicaid provider.

## TARGETED CASE MANAGEMENT FOR CHILDREN IN FOSTER CARE/RECEIVING CHILD PROTECTIVE SERVICES

A. **Target Group:** Children from birth through age seventeen who have been legally placed in the custody of the Department of Human Services by:

1) the youth court or chancery court; and
2) for whom custody with the Department of Human Services was not sought by the parents or legal custodians or guardians for the parent's or legal custodians' or guardians' legal responsibilities to relieve themselves of the responsibility for paying for treatment for a child or youth; AND
3)are unable to be maintained by the family or legal guardians or custodians due to his or her need for specialized care; OR
4) have been referred for abuse or neglect and for whom a case has been opened and is active in the Division of Family and Children's Services of the Department of Human services.

B. **Areas of the State in which services will be provided:**

X Entire State;

_____Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. **Comparability of Services:**

_____Services are provided in accordance with Section 1902(A)(10)(B) of the Act;

X Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. **Definition of Services**

Targeted Case management services are services which will assist an individual, eligible under the plan, in gaining access to needed medical, social, educational and other services through a set of interrelated activities which include:

1) Establishing the comprehensive case file including the development and implementation of an individualized service plan to meet the assessed service needs of the child;
2) Assisting the child in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;
3) Monitoring the child and service provider to determine that the services received are adequate in meeting the child's needs; or
4) Reassessment of the child to determine services needed to resolve any crisis situation resulting form neglect, maltreatment, exploitation, divorce, death, separation, changes in family structure or living conditions.

**TARGETED CASE MANAGEMENT FOR CHILDREN IN FOSTER CARE/RECEIVING CHILD PROTECTIVE SERVICES**

**E. Qualifications of Providers:**

Individual case managers must meet the following criteria:
1) A minimum of a Bachelor of Arts or a Bachelor of Science or a Masters degree in Psychology, Sociology, Social Work or a related field;
2) Licensed to practice as a Social Worker (LSW or above) in the State of Mississippi;
3) Successful completion of a practicum in case management approved by the Mississippi Department of Human Services, Division of Family and Children's Services and the Division of Medicaid that includes elements of children's social services, foster care and case management, care planning, use of community resources.

Case management agencies must meet the following criteria:
1) A minimum of five years of demonstrated experience in coordinating and linking community resources required by the target population;
2) A minimum of five years of demonstrated experience with the target population; and
3) A minimum of five years of demonstrated capacity to meet the case management service needs of the target population.
4) Ensure 24-hour availability of case management services and continuity of those services
5) Have administrative capacity to ensure quality of services in accordance with State and Federal requirements.
6) Have the capacity to document and maintain individual case records in accordance with State and Federal requirements.
7) Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

**F. Freedom of Choice**

The State assures that the provision of Targeted Case Management Services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act;

1) Eligible recipients will have free choice of the providers of Targeted Case Management.

2) Eligible recipients will have free choice of providers of other medical care as covered elsewhere under the Plan..

**G. Payment for Targeted Case Management Services** under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

20a. & 20b. Extended services to pregnant women. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

All Medicaid services are provided to pregnant women within the limits and policy of the Medicaid Program, as set forth in the State Plan.

Extended services may be provided as component parts of the services of any qualified Medicaid provider.

Extended Services (Nutrition,
Psychosocial, Health
Education, Home Visits)

*Description of services provided on following pages.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

EXTENDED SERVICES

1. **Medical Risk Assessment**

A medical risk assessment (screening) is done by a physician, a registered nurse/nurse practitioner under a physician's direction, or a certified nurse-midwife to determine if the patient is high risk. A pregnant woman is considered high risk if one or more risk factors are indicated on the form used for risk screening. The enhanced services are made available in cases of medical necessity when a medical risk assessment has determined that a pregnant woman has one or more factors which may adversely affect the pregnancy outcome.

A pregnant woman may be assessed (screened) for medical risk a maximum of two (2) times per pregnancy. A second medical risk assessment (screening) would be necessary only if the woman changed the provider responsible for her obstetrical care, and the new provider was unable to obtain the prior records.

Reimbursement for the medical risk assessment (screening) is to an approved physician or certified nurse-midwife provider. This is a separate fee, just as lab services are reimbursed apart from an office visit.

Providers of medical risk assessment (screening) have the option of using the Hollister Maternal Record or the Risk Screening Form, Mississippi Perinatal Risk Management/Infant Service System. Attached is a copy of high-risk referral criteria that includes the guidelines for use of the Hollister Maternal Record and the Risk Screening Form. Referral may be made to a Case Management Agency by submitting a copy of the Risk Screening Form, or by making a telephone call. When a telephone call is made, the Case Management Agency will document the referral on the Risk Screening Form.

2. **Nutritional Assessment/Counseling**

**A. Definition:**

**Assessment** is a review of the pregnant woman's dietary pattern and intake, her resources for obtaining and preparing food and evaluation of her nutritional needs.

**B. Counseling means services to include:**

(1) The development of a nutritional care plan based on the health risks identified due to nutritional factors.

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICE PROVIDED

(2) The follow-up and reassessment needed to carry out the nutritional care plan.

(3) The Division of Medicaid will utilize guidelines as promulgated in Maternal and Infant Health Guidelines, prepared by the Association of Maternal and Child Health Programs in association with the State Medicaid Directors' Association, as criteria for monitoring this service.

Nutritional assessment/counseling is covered for pregnant women with one or more medical risk factors which may adversely affect the pregnancy outcome. Counseling is appropriate for women whose complications require the services of a dietician/nutritionist for treatment of a pregnancy-related complication, e.g., diabetes, over/under weight. The services are provided by a registered dietician or licensed nutritionist. A combination of this service and/or psychosocial assessment/counseling may be provided a maximum of eight (8) times during the pregnancy and postpartum. The nutritional assessment is done by the registered dietician or licensed nutritionist, and is considered as one unit of nutritional assessment/counseling. If the pregnant woman is eligible for WIC, the nutritional assessment for this program will build upon the WIC assessment in order to prevent two programs from doing duplicate assessments. A second nutritional assessment will be allowed during the pregnancy, if the woman changes her provider, and the new provider is unable to obtain records for the previous provider.

**3. Psychosocial Assessment/Counseling**

**A. Definition:**

**Assessment** is an evaluation of the pregnant woman and her environment to identify psychosocial factors that may adversely affect the woman's health status.

**B. Counseling means services to include:**

(1) The development of a social work care plan based upon the health risks due to psychosocial factors.

(2) The follow-up, appropriate intervention, and referrals to carry-out the social work care plan.



TN No. 88-11 DATE/RECEIPT 12/23/88
SUPERSEDES DATE/APPROVED 3/17/89
TN No. NEW DATE/EFFECTIVE 10/1/88